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No. 96-1806

In the Supreme Court of the United States

OCTOBER TERM, 1996

THE MARYLAND PSYCHIATRIC SOCIETY, INC.,
PETITIONER

v.

MARTIN P. WASSERMAN, SECRETARY OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE,
ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF FOR THE FEDERAL RESPONDENT IN OPPOSITION

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QUESTION PRESENTED

Whether the 37.5% amount excluded under the Medicare Part B program in determining reimbursement for outpatient psychiatric services is "coinsurance," within the meaning of 42 U.S.C. 1396d(p)(3)(B), for purposes of determining the amount of state Medicaid payments made on behalf of Qualified Medicare Beneficiaries who are enrolled in the Medicare program.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1-23) is reported at 102 F.3d 717. The opinion of the district court (Pet. App. 28-71) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on December 16, 1996. A petition for rehearing was denied on February 11, 1997. Pet. App. 24-27. The petition for a writ of certiorari was filed on May 12, 1997. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTORY PROVISIONS INVOLVED

1. 42 U.S.C. 1395*l*(c) provides in relevant part:

> Notwithstanding any other provision of this part, with respect to expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital at the time such expenses are incurred, there shall be considered as incurred expenses for purposes of subsections (a) and (b) of this section only 62 1/2 percent of such expenses. * * *

2. 42 U.S.C. 1396d(p)(3) provides in relevant part:

> The term "medicare cost-sharing" means the following costs incurred with respect to a qualified medicare beneficiary, without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan:
>
> (A)(i) premiums under section 1395i-2 or 1395i-2a of this title, and
>
> (ii) premiums under section 1395r of this title,
>
> (B) Coinsurance under subchapter XVIII of this chapter (including coinsurance described in section 1395e of this title).

(C) Deductibles established under subchapter XVIII of this chapter (including those described in section 1395e of this title and section 1395*l*(b) of this title).

(D) The difference between the amount that is paid under section 1395*l*(a) of this title and the amount that would be paid under such section if any reference to "80 percent" therein were deemed a reference to "100 percent".

* * * * *

STATEMENT

1. a. Persons who are at least 65 years of age or disabled, and who meet certain other eligibility requirements, are automatically enrolled in Part A of the Medicare program, a federally funded hospital insurance program. See 42 U.S.C. 1395 *et seq.* Persons who are covered by Medicare Part A (and certain other persons) may purchase supplementary insurance for additional medical services under Part B of the Medicare program by paying premiums to the Supplemental Insurance Trust Fund. 42 U.S.C. 1395 *et seq.* A provider of medical services to Medicare Part B beneficiaries receives the federal Medicare payment (typically 80% of the applicable fee schedule amount for the services rendered), and the beneficiary is responsible for the remaining amount. See 42 U.S.C. 1395*l*(a)(1) and (b). In addition, Medicare Part B enrollees must pay a monthly premium and an annual deductible. See 42 U.S.C. 1395*l*(b), 1395r. A physician who elects to participate in Medicare agrees to "take assignment"—that is, to accept the

Medicare approved amount (the fee schedule amount) as payment in full. 42 U.S.C. 1395u(h).

Medicaid is a need-based program funded jointly by the federal government and participating state governments. See 42 U.S.C. 1396 *et seq.*; *Harris* v. *McRae*, 448 U.S. 297, 301 (1980). Under Medicaid, health care providers receive a specified sum for covered services, a sum that is established by the State through a fee schedule or other methodology. Providers generally must accept a State's payment for services covered under the Medicaid plan as payment in full, and may not seek to collect other than nominal payments for such services from the beneficiary or elsewhere. See 42 U.S.C. 1396*o*; 42 C.F.R. 447.15.

b. Some persons, such as the elderly poor, are eligible for coverage under both Medicare Part A and Medicaid. However, those individuals often lack the funds to pay Medicare Part B premiums. Congress addressed that problem by requiring participating States to enter into "buy-in" agreements with the Secretary of Health and Human Services. Under a buy-in agreement, the States enroll Medicaid recipients and others who are eligible for Medicare (and who meet statutory and income and resource requirements) in the Medicare Part B program. Medicaid funds are then used to pay those persons' Medicare Part B insurance premiums. See 42 U.S.C. 1395v, 1396d(a).

The only individuals who initially qualified for this Medicare "cost-sharing" were those who were "dual eligibles"—*i.e.*, persons who were eligible for both Medicare and Medicaid services. In 1986 and 1988, however, Congress broadened the class of persons potentially eligible for Medicaid-financed enrollment

in the Medicare Part B program to a larger class of individuals known as Qualified Medicare Beneficiaries or "QMBs." See Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9403, 100 Stat. 2053-2054; Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 301, 102 Stat. 748 (codified at 42 U.S.C. 1396a(a)(10)(E), 1396d(p)); Technical and Miscellaneous Revenue Act of 1988, Pub. L. No. 100-647, § 8434, 102 Stat. 3805; H.R. Conf. Rep. No. 1104, 100th Cong., 2d Sess. 284 (1988).

c. As explained above, the federal government typically pays 80% of the fee schedule amount for services provided under Medicare Part B. As a general rule, a regular Medicare beneficiary may be charged the 20% amount that remains. A QMB, however, may not be charged that 20% amount. See 42 U.S.C. 1396*o*(a).

Since at least 1971, the Secretary has taken the position that States need not pay the 20% copayment in full on behalf of QMBs, but rather may limit their payment for cost-sharing to the amount (if any) by which the Medicaid rate for the service provided exceeds the amount that Medicare Part B has paid. Several courts of appeals, however, rejected the Secretary's interpretation of the original Act and the 1986 and 1988 amendments, described above. See *Rehabilitation Ass'n of Virginia, Inc.* v. *Kozlowski*, 42 F.3d 1444 (4th Cir. 1994), cert. denied, 116 S. Ct. 60 (1995); *Haynes Ambulance Serv., Inc.* v. *Alabama*, 36 F.3d 1074 (11th Cir. 1994); *Pennsylvania Medical Soc'y* v. *Snider*, 29 F.3d 886 (3d Cir. 1994); *New York City Health & Hosps. Corp.* v. *Perales*, 954 F.2d 854 (2d Cir.), cert. denied, 506 U.S. 972 (1992). In those circuits, therefore, States were required to pay in full any amounts that constitute "medicare cost-sharing,"

as defined by 42 U.S.C. 1396d(p)(3).[1] Because Maryland was required to comply with the Fourth Circuit's decision in *Koslowski*, it has recently been paying, in full, the 20% cost-sharing amount. Since the petition for a writ of certiorari was filed, however, Congress amended the Medicare Act to provide—contrary to the result reached by the four courts of appeals—that the States are *not* required to pay the various categories of Medicare cost-sharing for QMBs to the extent the total amount of the State's payment would exceed the State's Medicaid ceiling. See Balanced Budget Act of 1997, Pub. L. No. 105-___, § 4714, _____ Stat. _____ (reproduced at 143 Cong. Rec. H6096 (daily ed. July 29, 1997)); 143 Cong. Rec. H6252 (daily ed. July 29, 1997) (House Conference Report).

d. This case does not present the broader issue that was involved in the four court of appeals decisions cited above and that was recently resolved by Congress. Rather, the issue here is whether a separate amount not paid by Medicare Part B for mental health services constitutes "medicare cost-sharing" within the meaning of Section 1396d(p)(3). While the usual formula for Medicare reimbursement is 80% of the fee schedule amount, that is not the case with respect to outpatient mental health services,

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[1] The United States District Courts for the Northern District of California and the Western District of Wisconsin recently upheld the Secretary's position that a State could limit its cost-sharing payments to the difference between its Medicaid rate and what Medicare pays. See *Dameron Physicians Medical Group, Inc.* v. *Shalala*, 961 F. Supp. 1326 (N.D. Cal. 1997), appeal pending, No. 97-15753 (9th Cir.); *Kulkarni* v. *Leean*, No. 96-C-884-S (W.D. Wis. June 23, 1997), appeal pending, No. 97-2684 (7th Cir.).

which are reimbursed at a significantly lower rate. Medicare pays only 50% of the cost of outpatient psychiatric or other mental health services. That limitation is set forth in 42 U.S.C. 1395*l*(c), which provides that, notwithstanding any other provision of Medicare, only 62.5% percent of the fee schedule amount for outpatient mental health care is to be considered "incurred." Medicare then pays 80% of that incurred amount, and 80% of 62.5% yields a Medicare payment of 50% of the fee schedule amount. The issue in this case is whether the 37.5% not paid by Medicare Part B must be paid by state Medicaid programs on behalf of QMBs who have incurred costs for outpatient psychiatric services.

2. a. Petitioner, an association of psychiatrists, brought suit to compel the Maryland Medicaid program to pay the 37.5% amount on behalf of QMBs, arguing that the 37.5% amount is "coinsurance" within the meaning of Section 1396d(p)(3)(B). Petitioner challenged both Maryland's policy and the conclusion of the Secretary of Health and Human Services that, although the 37.5% amount bears some resemblance to coinsurance, in that it is an amount that Medicare does not pay and that a health care provider may collect from the beneficiary, the 37.5% amount is not "coinsurance" within the meaning of Section 1396d(p)(3)(B), the statutory section that defines what is included in the State's obligation to pay Medicare cost-sharing.

b. The district court granted petitioner's motion for summary judgment. Pet. App. 28-71. The court concluded that the 37.5% amount is "coinsurance" within the meaning of Section 1396d(p)(3)(B). The court relied on a dictionary definition of "coinsurance," and ruled that the 37.5% amount fell

"squarely within the ordinary concept of coinsurance as a shared obligation or 'joint assumption of risk.'" *Id.* at 56-57 (quoting *Webster's Ninth New Collegiate Dictionary* 257 (1986)).

c. The court of appeals reversed, rejecting the district court's reading of the Medicare and Medicaid Acts. Pet. App. 1-23. "If Congress intended states to pay the 37.5% exclusion for outpatient psychiatric services," the court of appeals reasoned, "it certainly did not say so explicitly, clearly, and unambiguously. The QMB provisions do not mention the exclusion at all." *Id.* at 9. Finding that the district court's reliance on the dictionary definition of the term "coinsurance" rendered other provisions of the Act "superfluous" (*id.* at 10-11), the court read the term "coinsurance" to refer specifically to those expenses that Congress identified as "coinsurance" in the statutory sections to which Section 1396d(p)(3)(B) refers. *Id.* at 12. The court further held that, because no provision in the Medicare or Medicaid Act explicitly covers the 37.5% exclusion, to impose such a burden on the States would be impermissible, in light of this Court's decisions in *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), and *Pennhurst School and Hospital* v. *Halderman*, 451 U.S. 1 (1981). Pet. App. 8-9, 14-17.

ARGUMENT

The decision of the court of appeals is correct and does not conflict with any decision of this Court or of another court of appeals. Accordingly, certiorari should be denied.

1. "The power of an administrative agency to administer a congressionally created * * * program necessarily requires the formulation of policy and the

making of rules to fill any gap left, implicitly or explicitly, by Congress." *Morton* v. *Ruiz*, 415 U.S. 199, 231 (1974). Accordingly, this Court held in *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), that where Congress has not expressed its intention on the precise question at issue, courts should defer to a reasonable interpretation by the agency charged with administering the program. *Id.* at 844.

In this case, Congress has not spoken directly to the question at issue. Neither the Medicaid Act nor the Medicare Act provides how the 37.5% excluded from reimbursement for outpatient psychiatric services for QMBs is to be treated. As the court of appeals put it, "nothing in the statute mentions who, if anyone, is required to pay the excluded amount for QMB patients." Pet. App. 9. "The QMB provisions do not mention the exclusion at all." *Ibid.* Accordingly, the Secretary's interpretation is entitled to deference so long as her reading is permissible. The touchstone for that determination is reasonableness. 467 U.S. at 844, 845.[2]

The Secretary's interpretation is plainly reasonable. The Secretary construes the word "coinsurance" to refer only to those expenses that

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[2] The Secretary had earlier taken the position that the 37.5% exclusion was "coinsurance," but subsequently changed her interpretation. Pet. App. 17. Of course, as this Court stated in *Chevron*, a case that itself involved a change in the agency's position, "[t]he fact that the agency has from time to time changed its interpretation * * * does not * * * lead us to conclude that no deference should be accorded the agency's interpretation of the statute. An initial agency interpretation is not instantly carved in stone." 467 U.S. at 863-864. Accord *Rust* v. *Sullivan*, 500 U.S. 173, 186-187 (1991).

Congress expressly identified as coinsurance in the Medicare Act itself. For example, 42 U.S.C. 1395e, which is expressly mentioned in 42 U.S.C. 1396d(p)(3)(B) and addresses cost-splitting for purposes of outpatient hospital care, specifically identifies as "coinsurance" certain costs that are not covered by Medicare. See 42 U.S.C. 1395e(a)(1) ("The amount payable for inpatient hospital services * * * shall be reduced * * * by a coinsurance amount."). Similarly, Medicare amendments enacted in 1988—when Section 1396d(p)(3)(B) was amended to provide for the inclusion in the definition of QMB cost-sharing of coinsurance in addition to that under Section 1395e—referred to the States' obligations with respect to newly enacted coverage for prescription drugs as "coinsurance." Those amendments provided that the State's share of the prescription drug cost was to be 50% in 1990 and 1991, 40% in 1992, and 20% in 1993—a marked departure from the usual obligation of the States.[3] To emphasize that alteration in the expense-sharing formula, Congress expressly identified the States' prescription drug obligation as "coinsurance." Medicare Catastrophic Coverage Act of 1988, Pub L. No. 100-360, § 202(b)(4), 102 Stat. 706.[4] Congress made conforming amendments to Section 1396d(p)(3)(B), the statutory section describing the cost-sharing that the States are required to cover, by providing for cost-sharing to

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[3] The special prescription drug provisions have since been repealed.

[4] The provision cited in the text is entitled "Coinsurance percent" and provides that "the coinsurance percent" shall be the percentages quoted above for the years 1990-1993 and succeeding years.

include coinsurance in addition to that identified in Section 1395e.[5] See, *e.g.*, § 301(d)(2), 102 Stat. 749.

By contrast, Congress did not refer to the 37.5% amount excluded from outpatient psychiatric services as "coinsurance" in Section 1395*l*(c), which establishes that exclusion. Moreover, the 37.5% exclusion is conspicuously absent from Section 1396d(p)(3), the section that defines the cost-sharing obligations of the States with respect to QMBs. As the court of appeals correctly observed (Pet. App. 13), "[u]nlike the 1988 prescription drug obligations, the 37.5% amount is not called coinsurance in the provision that excludes that amount from Medicare reimbursement, 42 U.S.C. § 1395*l*(c). Nor does section 1396d(p)(3)(B) explicitly cross-reference or include the 37.5% exclusion in its terms." There accordingly is no support in the text of the Medicare and Medicaid Acts for treating the 37.5% exclusion as an obligation of the States.

Petitioner argues that its members are entitled to reimbursement for their full psychiatric fees and that any shortfall must be made up by the States. Not only does the statutory language fail to support that theory, but the Medicare and Medicaid Acts never have guaranteed full recovery. Under Medicare Part B, the federal government's obligation is typically 80% of reasonable charges; the additional 20% may be sought from those individuals who purchase Part B insurance for themselves, but there is no guarantee

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[5] The Conference Report confirms that the expanded reference to coinsurance in Section 1396d(p)(3)(B) was intended to accommodate the new prescription drug provisions. See H.R. Conf. Rep. No. 661, 100th Cong., 2d Sess. 253-254 (1988).

of payment. Under Medicaid, recovery is limited to the Medicaid fee schedule amounts (or other amounts determined under other methodologies established by the States). Thus under both the Medicare and Medicaid provisions, Congress obviously never intended that providers would receive full payment from the government for their charges. Such a result would be particularly anomalous here, where Congress, in a general policy dating from the beginning of the Medicare program, has limited reimbursement for outpatient psychiatric services to 50% of the reasonable charge. As the court of appeals correctly observed, "[i]t would be ironic to conclude that when Congress designates a particular service for lesser funding it expects states to spend a greater percentage of their limited Medicaid funds on that disfavored service." Pet. App. 21-22.

Petitioner's interpretation of the Medicare and Medicaid Acts also is critically undermined by the overall structure of the statutory scheme. It is a cardinal rule of statutory interpretation that a statute should be construed in a manner that gives effect to all of its provisions. See, *e.g.*, *Dickerson* v. *New Banner Inst., Inc.*, 460 U.S. 103, 118 (1983). The Secretary's interpretation satisfies that canon, but petitioner's interpretation does not. Petitioner reads the term "coinsurance" in Section 1396d(p)(3)(B) expansively to include *any* payment obligation shared by the federal government and a state Medicaid program. If petitioner were correct, then, as the court of appeals concluded, "it would certainly encompass the 20% copayment required of states under the QMB program. If that were true, Congress would not have needed to include section 1396d(p)(3)(D), which requires the states to pay the

20% copayment for QMBs." Pet. App. 11. Petitioner's reading, in other words, renders a key statutory section redundant and superfluous.

2. There is no conflict in the circuits on the narrow issue of statutory interpretation presented in this case. The decision below is the only ruling on the issue from a federal court of appeals. Petitioner attempts to manufacture a conflict by arguing that the decision below conflicts with decisions of three courts of appeals that held—for services other than mental health services—that the States must pay the 20% amount on behalf of QMBs. See Pet. 15-18. Petitioner fails to acknowledge, however, that the court below, in its earlier *Koslowski* decision, joined those other circuits regarding the more general 20% payment obligation, but nonetheless held in this case that a State does not have to pay the 37.5% exclusion for mental health services. In other words, the Fourth Circuit is in agreement with the very cases petitioner cites as conflicting with the decision below. Moreover, as explained above (see page 6, *supra*), Congress has recently amended the Medicare Act in a manner that supersedes the interpretation of Section 1396d(p)(3) in the appellate decisions upon which petitioner relies. In light of Congress's recent action to ensure that the States have flexibility to decline to pay cost-sharing in excess of their Medicaid ceilings, petitioner's argument that States must pay the 37.5% exclusion for mental health services is particularly ill-founded.

3. Petitioner's argument that the court of appeals misapplied this Court's decision in *Pennhurst* does not warrant review. In light of *Chevron* principles, this Court need not decide whether *Pennhurst* requires that the scope of obligations imposed on

States pursuant to Congress's Spending Power be clear and unambiguous. *Pennhurst*'s requirement of heightened clarity applies only to the creation of enforceable rights, not to the scope of rights that are clearly enforceable. See, *e.g.*, *Illinois* v. *Sullivan*, 919 F.2d 428, 433-434 (7th Cir. 1990) ("The case before us, [unlike *Pennhurst*], involves not *whether* enforceable obligations were created * * * but rather the scope and interpretation of those obligations."). The court of appeals did not analogize the facts of this case to those in *Pennhurst*. Rather, the court deferred to the Secretary's interpretation of the Medicare and Medicaid Acts. It noted, in the process, not only that the Secretary's interpretation was reasonable, but also that petitioner's reading would saddle the States with financial burdens that were not part of their original bargain with the federal government. The court cited *Pennhurst* for the unobjectionable principle that "[t]he case for inferring intent is at its weakest" in such circumstances. Pet. App. 14.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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